

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nevada

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PAYMENT FOR LONG TERM NURSING FACILITY SERVICES

Payment is made for services provided in nursing facilities, including nursing facilities for the mentally retarded, in accordance with 42 CFR Part 447, Subpart C. Payments are consistent with efficiency, economy, and quality of care and may never exceed a facility's customary charges. Reimbursement of transportation service in Clark, Washoe, Churchill, and Carson City counties nursing facilities is an exception to the general rule that reimbursement is made in accordance with 42 CFR Part 447, Subpart C.

METHODS AND STANDARDS

A. Hospital-Based Facilities: (Hospital-based facility is defined as: a) a facility sharing a common building or common tract of land with a hospital owned or operated by the state, or an instrumentality or unit of government within the state, located within a county of a population of 100,000 or less; or b) a facility (public or private) which prior to July 1, 1992, was paid for both inpatient hospital services under Attachment 4.19-A of the Medicaid State Plan and long-term nursing facility services under this section.)

1. Long term care services are paid for under Medicare principles of reimbursement described in 42 CFR 413, including the routine cost limitations specified in 413.30 and further specified in HCFA Publication 15.
2. In no case may payment for hospital-based long term care services exceed the provider's customary charges to the general public or the Medicare payment to the hospital for extended care facility services.
3. Each facility is reimbursed the lower of 1) billed charge; or 2) an interim percentage of billed charges which is the ratio of costs to charges from the facility's most recently audited cost reporting period.

B. Free-standing Facilities: (Free-standing facility is defined as any other facility providing nursing services.)

1. A prospective per diem rate is set for all costs, except those currently associated with property, return on equity, and certain ancillaries.
  - a. Nevada Medicaid generally follows the guidelines of the Medicare Provider Reimbursement Manual, parts one and two (HIM 15). In addition, Nevada Medicaid imposes the following limitations on cost:

1) Salaries:

Administrator	\$40,000 per year
Assistant Administrator	\$30,000 per year

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Where a facility does not employ an assistant administrator, the administrator and assistant administrator salaries may be combined and then multiplied by the appropriate percentage as follows:

<u>Facility Size</u>	<u>% of Combined Salary</u>
151-170 beds	70%
171-190 beds	75%
191 and above	80%

These above limitations will be effective for facilities for cost reports ending in calendar year 1991. The limitations will be indexed forward annually by the percentage increase in the "Consumer Price Index for All Urban Consumers, All Items" for the previous calendar year. The facility size applies to weighted average licensed beds for the cost report period.

For purposes of determining whether the compensation paid to or claimed by an administrator or assistant administrator is reasonable and falls within the maximum allowable salary limitation, salary and benefits not generally available to all employees on an equal basis and remuneration, regardless of form, will be considered. Examples of items to be included in the comparison are salary, automobile provided, license fees, and other perquisites not granted to other employees.

2) Consultant Costs:

Medical Director - the greater of 20¢ per patient day or \$400 per month.

Pharmacist Consultant - 17¢ per patient day.

Dietary Consultant - 14¢ per patient day.

Social Worker Consultant - 13¢ per patient day.

Activities Consultant - 13¢ per patient day.

Medical Records Consultant - 8¢ per patient day.

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3) Other Areas:

In addition, we propose to limit the State Industrial Insurance System rate to the manual premium. This limit is to encourage nursing facilities to emphasize safety at work and lower their experience rating.

- 4) All costs limited per this subsection will be reviewed for reasonableness and adjusted as appropriate at least every four years, beginning with rates effective July 1, 1996.

b. Audited per diem costs from the latest available cost reports are used subject to the limitations described in paragraph B.1.a. Routine cost limitations and lower of cost or charges are not applied to the costs used for rate development.

- 1) The cost reports to be used are for nursing facilities with fiscal years June 1 through May 31 of the preceding year. For example, the rate effective July 1, 1996 would be based on cost reports from nursing facilities with fiscal years ending June 1, 1994 through May 1995. The cost report shall be filed with the same as follows:

- a) Nursing facilities must file their costs reports with the state or its designee within 90 days of the end of their fiscal year. The cost report shall be sent to the state by certified mail, return receipt requested.
- b) The state or its designee will notify each nursing facility whether the cost report is complete within 15 days of the state's or its designee's receipt of the cost report. The state or its designee will base its assessment of whether the cost report is complete on an objective pre-audit check list. Each nursing facility will have 15 days from the date the nursing facility receives notice from the State or its designee that its cost report is not complete to provide an adjusted cost report.

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- c) If a nursing facility fails to submit a complete cost report by September 30 of any year, the incomplete cost report will not be used in the July rate setting. If this occurs, the state or designee will use the nursing facility's final audited cost report for the prior year and will inflate the final audited cost report by the Urban & Wage Consumer Price Index.
  - d) If the state or its designee accepts a nursing facility's cost report as complete by September 30 of the year and the preliminary audit of that nursing facility is not completed by April 30 of the following year due to no fault of the nursing facility, the state or its designee shall use the nursing facility's unaudited cost report for July rebasing, adjusted by the audit adjustment applied to the nursing facility's latest final audited cost report identified as of March 31 of that year.
  - e) The state or its designee may disallow costs if the nursing facility fails to provide sufficient documentation to support the cost report within the specified audit procedure time period.
- 2) All costs are indexed to a common point for comparability. For instance, most cost reports have an ending date of December 31. To minimize indexing, this date is used as the common point. If, for example, a cost report ended earlier in the year on June 30, a six-month index factor would be added to adjust those costs to the December 31 point. For the period of six-month recalculation, the common point is moved forward six months with each rebasing.

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c. The audited per diem costs, described above, will be adjusted to reflect changes in nursing hour requirements which may occur between the date of the cost report and the effective date of the rates. Changes to the reported costs will be calculated as follows:

- 1) The new maximum direct care hours are calculated by multiplying patient days by level of care times the new maximum direct care hours.
- 2) The new maximum direct care hours are subtracted from the old maximum direct care hours to determine the change in the maximum direct care hours.
- 3) The change in the maximum direct care hours is multiplied by the actual staffing percentage of maximum (actual direct care hours divided by old maximum direct care hours) to develop the change in actual direct care hours.
- 4) The change in actual direct care hours is multiplied by the per hour direct care cost to develop the actual change in direct care salary cost.
- 5) The change in actual direct care salary cost is multiplied by the percentage of benefits to total salaries as reported on the cost report. This generates the change in benefits related to the change in direct care salary cost.
- 6) The change in the actual direct care salary cost is added to or subtracted from the total health care cost reported on the cost report. This represents the projected health care cost (unindexed) for the rate period.
- 7) The projected health care cost is divided by the new maximum direct care hours to generate a cost per patient hour.
- 8) The cost per patient hour is multiplied by the maximum direct care hours for each level of care. This represents the new health care cost per level of care.
- 9) The change in employee benefits is allocated in a similar manner.

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- 10) Once the new health care and employee benefit costs are known, they are added to the remaining cost centers to develop the total cost per patient day by level of care.
- d. All indexing is based on the most recently available Urban Wage and Clerical Index published by the Bureau of Labor Statistics. For purposes of indexing to a common point as described in b.(2) above, the actual inflation amounts from the appropriate periods are used. To index rates forward into future time periods, the projection index is determined by using an average of the latest six months data from the Urban Wage and Clerical Index. For instance, if the common index point was December 31, 1987 and it was necessary to index the rate developed at this point forward to December 31, 1988, the latest six months of inflation figures would be averaged and then annualized to reflect one year of anticipated inflation. This factor would then be applied to the December 31, 1987 base rates to index them forward one year.
- e. The various costs, except property related, are arranged from the most to the least expensive within various categories of reimbursement. These categories are based on the amount of nursing time that an individual patient has been determined to require through a formal assessment process. These hours reflect the acuity of the patient and the resources which will be needed for adequate care. Presently, six categories of reimbursement exist; however, these may be adjusted from time to time either in number of hours or categories to reflect changes in covered services, changes in technology, or general patient patterns of acuity. Such changes will be made only on the basis of documented evidence including, but not limited to, time studies and resource utilization analysis.

Currently, the range of nursing hours defined for each category are the following:

<u>Category of Reimbursement</u>	<u>Allowable Nursing Hours</u>
1	.75 to 1.00
2	1.50 to 1.75
3	2.50 to 2.75
4	3.00 to 3.75
5	4.00 to 5.75
6	6.00 to 10.75

- f. The 60th percentile facility, measured from the least expensive, for each category of reimbursement, is determined. This point is interpolated between two facilities if necessary.

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- g. The per diem cost by category of reimbursement for facilities identified in 'f' is then indexed forward to the mid-point of the new rate period using the indexing described in 'd'. For instance if the rate at the 60th percentile was based on December 31 data and the rates were to be effective in the following July to June period, the rates would be indexed forward from the base December 31 period one year to the December 31 falling in the July to June rate period.
  - h. Rates developed using this method were originally implemented January 1, 1988 for the period of January 1 through June 30, 1988. Recalculation to develop new rates will be done for each six month period, January through June and July through December, until July 1, 1989. At that time they will only be recalculated annually to correspond with the state fiscal year, July 1 through June 30.
2. Property is reimbursed on a prospective rate for each individual facility. Exceptions to this are described in 'f.' below:
- a. Audited costs are used from the same cost report data described in B.1.b. above. However this is not indexed to a common point.
  - b. In some circumstances when a recent appeal has established more current cost information than is available from the cost report, the costs determined in the appeal are used.
  - c. Once the basic rate has been calculated from either step 'a' or 'b' above, this amount is indexed to the current rate period.
  - d. The index factor used is determined by measuring the percentage change in property costs for Nevada facilities in the aggregate between the two most recently audited years. The property costs used are those of owned facilities since the inflation factor is designed to reflect the average cost increase of an owned facility including such item as changes in property tax, insurance, and routine replacement equipment purchases. (Major lease costs are excluded from this calculation. These major lease costs are for the building and land. If the lease also includes the moveable property within the building, it would be considered part of the major lease cost. The limitation described in 2.f.(4) would apply to these leases.) Leases for individual pieces or small groups of equipment are considered to be minor and are treated as if they were owned for the development of the inflation factor. For instance, if the audited property costs available on December 31 of the current year was \$3,000,000 for all Nevada facilities and the

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total for the previous audited period was \$2,950,000 the increase would be 1.7% per year and this would be the indexing factor used to index to the new rate period. Facilities which have experienced major changes as described in 'f.' will not be included until they have established two consecutive audited years of only non-major (routine) cost changes. This prevents distortions which could occur if the audited years being compared to develop an index were not consistent and, therefore, not properly comparable.

- e. For each new rate period the process described in steps in a-d above is repeated and new rates established. The rate periods are the same as those defined in B.l.h. This system provides for frequent recalculation of property costs and allows a reasonable but limited increase to cover routine cost increases such as might occur from increases in taxes or insurance.
- f. Certain events may occur which would result in major changes in property costs for a facility. These events are listed below. Facilities which undergo major changes will be placed on an interim property rate subject to retrospective settlement when audited. It is incumbent on each facility to notify the Medicaid fiscal agent if they have experienced a major change. Related financial records should be included with the notification. These records will be used as the basis to establish an interim rate. The interim rate will be paid in place of the current prospective rate. Once the appropriate costs are established through audit, the facility will then be changed to the prospective reimbursement methods.
  - 1) Sales: Facilities sold after July 1, 1988 will be subject to the re-evaluation of assets as allowed in the Consolidated Omnibus Budget Reconciliation Act of 1985. Sales prior to this date continue to be limited to the restrictions of the Deficit Reduction Act of 1984.
  - 2) New Facilities: These providers are subject to the following limitations: The term 'bed' refers to Medicaid certified beds. It is assumed that beds applied for in the Certificate of Need process will eventually be certified if constructed.
    - a) Cost per bed - Set at the 60th percentile of costs submitted in the most recent application for Certificate of Need approval. This will be updated periodically as appropriate new data becomes available or indexed each year using the Marshall Valuation Index for Nursing Homes.

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- b) Financing - Eighty percent of Medicaid allowable facility costs may be financed with the interest rate limited to the prime rate plus three percentage points.
  - c) Land per bed - Limited to .04 of an acre per bed.
  - d) Square footage per bed - This is limited to 400 square feet.
- 3) Additions: These would result in the physical expansion of the facility and would be subject to the same limits described in '(2)' above. Nonduplicated components such as kitchens would be factored out of the maximum allowable costs per bed to prevent this limit from being too high for additions when compared to a completely new facility.
- 4) Leases: A capitation is applied to new leases. This limit is calculated by using the current maximum allowable Medicaid cost for new bed construction (2)(a) and adjusting it by the Marshall Valuation Index for Nursing Homes to the construction date of the facility. This amount is then indexed forward by one-half of the nursing home component of the Marshall Index or the Consumer Price Index to the inception point of the lease. The result is a cost limit per bed. In order to determine annual allowable amount, the allowable cost is multiplied by the current prime interest rate plus three percentage points. This product is divided by 365 days to determine a daily maximum per bed. For example:

Cost Limit per new bed	\$33,000
less total Marshall Index	
back to construction date	- 15%
Calculated cost limit at	\$28,000
point of construction	
Plus allowable cost increase	+ 7.5%
based on one-half of the	
Marshall Index	
Cost limit per bed	\$30,154
Multiplied by prime rate (10%)	13%
plus three percentage points	
Annual reimbursement cost limit	\$ 3,920
Divided by 365 days per year to	\$ 10.74
yield per diem capitation	

Increases during the term of the lease will be allowed each three years up to the lesser of the cumulative increase in the nursing home component of the Marshall Valuation Service or the Consumer Price Index.

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- g. The limitations defined in 2.f.(2)(a)-(d) above will be applied to all new facilities and additions to existing ones. The lease capitation applies to all new leases regardless of the age of the facility.
  - h. For purposes of the property rate determination, the occupancy factor of 92% or actual, whichever is greater, shall be applied. (For properties that are leased, the lease cost shall be excluded before applying the occupancy factor. The result shall be added to the lower of the lease capitation rate determined in paragraph B.2.f.(4) or the actual lease cost.)
- C. For addition to the basic rates and reimbursement previously described, the following do apply:
- 1. The lower of billed charges or a reimbursement amount developed under sections 'A' and 'B' above is paid each facility based on the categories of reimbursement to which patients have been assigned.
  - 2. A financial penalty is added to further assure quality of care is not affected by the adoption of a prospective rate. At the time a facility files its cost report, the minimum number of nursing hours which should have been provided will be calculated and compared to actual hours provided. If the facility falls below the minimum requirement, the difference in cost will be established and becomes the penalty amount. Final adjustments to the penalty, if needed, will be made at the time of audit. The penalty will be renewed through an offset against the future claims. When claims are no longer being received, direct payment will be required by the provider.
  - 3. Additional reimbursement as required by the Omnibus Budget and Reconciliation Act of 1987 (OBRA 87) is provided as follows:
    - a. Additional patient trust fund administrative costs: Compensation is added to cover the cost of five hours of overtime pay for an account clerk in each facility.
    - b. Transfer of patients: One-half hour of additional clerical time per five-day work week is added to the cost of each facility to compensate for the activity.

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